DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 11/20/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445420	A. BUILDING _____ B. WING _____	10/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SISKIN HOSPITAL SUBACUTE REHAB	ONE SISKIN PLAZA CHATTANOOGA, TN 37403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to follow physician's orders for one (#1), failed to obtain a physician's order to administer a medication for one (#5), and failed to ensure a care plan was developed to address dialysis for one (#6) of ten residents reviewed. The findings included: Resident #1 was admitted to the facility on September 29, 2010, with diagnoses including Status Post Right Knee Arthroscopy, and Hypertension. Medical record review of a physician's order dated September 29, 2010, revealed "...Furosemide (diuretic) 20 mg (milligram) tablet, 10 mg PO (by mouth) !!! NOTE DOSE (half tab) -Q (every) day..." Medical record review of the Medication Administration Records (MARs) revealed the resident received Furosemide 20 mg on September 30, 2010, and October 1-5, 2010, (a total of six days). Observation on October 5, 2010, at 7:36 a.m., revealed the resident seated in a wheelchair in the resident's room. Continued observation revealed Licensed Practical Nurse (LPN) #1 was	F 281	For all identified problems in this area, systems were reviewed. These reviews involved the director of nursing, the administrator, the medical director, and the pharmacy director. Actions include immediate steps to correct specific problem, policy changes, staff education and performance improvement indicators or audits to ensure no reoccurrence of unacceptable practice. Details of the Plan of Correction for each incident follow. 1. For resident # 1 nurse failed to follow physician order. Immediately, the correct order was processed by the pharmacy and the MAR was corrected. Initially, the nursing and pharmacy staff will participate in a review of the MAR verification process. As pharmacists are performing other entry from a valid signed transfer MAR (as in the case here) they will highlight all auxiliary notes that will become a part of the new entry. An audit will be performed to see that this is happening. As further errors are identified, individual nurses will receive individual counseling/training. Random audits of the medication process will be conducted. This audit will include referring facility records,	11/12/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Deana J Miller, NHA — 10/20/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

OCT 25 2010

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	445420	A. BUILDING _____ B. WING _____	10/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SISKIN HOSPITAL SUBACUTE REHAB	ONE SISKIN PLAZA CHATTANOOGA, TN 37403

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F 281	Continued From page 1 administering medications to the resident and Furosemide 20 mg was administered to the resident. Observation on October 5, 2010, at 8:08 a.m., and review of the resident's MAR located on the medication cart, with LPN #1, revealed "...Furosemide 20 mg tablet, dose 20 mg by mouth QAM (every morning)..." Observation and review of the medication label for Furosemide 20 mg, indicated the resident was to receive a tablet of Furosemide 20 mg daily, and there was no notation a half tablet was to be administered. Interview on October 5, 2010, at 8:08 a.m., with LPN #1, in the hallway, confirmed LPN #1 had administered Furosemide 20 mg to the resident on October 5, 2010, at 7:36 a.m., and confirmed the physician's orders were not followed. Interview and review of the physician's orders and the MARs, on October 5, 2010, at 10:00 a.m., with the Director of Nursing, in the conference room, revealed the physician's order for Furosemide 10 mg had been transcribed in error, and the resident had received Furosemide 20 mg in error on September 30, 2010, and October 1-5, 2010. Continued interview confirmed the physician's orders were not followed. Resident #5 was admitted to the facility on September 18, 2010, with diagnoses including Left Knee Osteoarthritis, Diabetes Mellitus, Anemia, status post Left Total Knee Arthroplasty, and Hyperlipidemia. Medical record review of Physician's Orders dated September 27, 2010 at 2:20 p.m. revealed, "...Levaquin (antibiotic) 500 one po (by mouth)	F 281	orders, MAR, verification documentation and administration documentation. Medication errors will continue to be documented on the Unusual Occurrence report and reviewed on a weekly basis for two months and then a monthly basis for 10 months. These findings will be reported and discussed at the Medical Management and Clinical Practices (MMCP) and the Performance Improvement (PIC) Committees. Additional actions will be taken as deemed appropriate by the committee members. 2. For resident # 5 a medication was administered without a proper physician order. Immediately, a physician order was obtained to discontinue the medication and the remaining doses were returned to pharmacy. The procedure for handling a medication order with pending authorization was revised. Beginning immediately, no medication will be dispensed until an authorization order is received in the pharmacy. To alert the nursing staff to the pending authorization order, the pharmacist will manually place a flag on the MAR	

Diane J Miller, NHA 10/20/10

OCT 25 2010

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	445420	A. BUILDING _____ B. WING _____	10/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SISKIN HOSPITAL SUBACUTE REHAB	ONE SISKIN PLAZA CHATTANOOGA, TN 37403

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F 281	Continued From page 2 daily. Begin today if OK with Dr...'s office..." Medical record review of PM&R Inpatient Progress Note dated September 27, 2010, revealed "...Begin Levaquin 500 one po daily...Left message with Dr...'s nurse...-to return my call..." Medical record review of the Medication Administration Record dated September 24 through October 7, 2010, revealed an entry on September 27, 2010, "...Levaquin 500 one po daily begin today if OK with Dr...'s office..." Continued review revealed no documentation the Levaquin had been given on September 27,28,29,30, and October 1, 2010. Further review revealed the Levaquin had been documented as administered on October 2,3,4,5, 2010. Interview with Pharmacist #1 on October 6, 2010, at 12:20 p.m., confirmed the Levaquin had been dispensed and returned to the pharmacy as not given, on September 27,28,29,30, 2010, and had not been returned to the pharmacy on October 2,3,4,5,2010. Interview with the Director of Nursing (DON) on October 6, 2010, at 10:45 a.m., in the Administrator's office, confirmed the Levaquin was documented as given on October 2,3,4,5, 2010. Continued interview with LPN #2, at 10:50 a.m., confirmed she administered the Levaquin on October 2nd and 3rd ,2010. Interview with Physician's Assistant #1 on October 6, 2010, at 11:20 a.m., in the Conference room confirmed an "OK" had not been obtained from the Dr...'s office, and confirmed the Levaquin was given without a physician's order.	F 281	as an informational alert. This flag will remain on the MAR until final approval is obtained, at which time a valid med order will be processed as normal. Beginning immediately, the pharmacy staff will initiate an audit of all medication orders with pending authorization. The results of these audits will be reviewed with medical staff at the MMCP meetings. Recommendations from MMCP members will be used to further revise the policy, as needed. 3. For resident #6 a dialysis care plan was not developed. Immediately, nursing staff initiated a care plan to address the patient's actual and potential needs related to dialysis. This care plan includes documented daily assessment of the vascular access device. A review of dialysis care planning has been provided to the nursing staff. In addition, a general review of the importance of individualized care plans is being developed. Indicators and audits of the care planning process have been incorporated into the Performance Improvement Plan. Any relevant findings will be discussed with PI	

Diana A Miller, NHA 10/20/10

OCT 25 2010

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F 281	Continued From page 3 Resident #6 was admitted to the facility on September 27, 2010, with diagnoses including Bilateral Lower Extremity Lymphedema, End Stage Renal Disease on Dialysis, Morbid Obesity, Arteriovenous Fistula Formation, and Anemia. Medical record review of the Admission Assessment Report dated September 27, 2010, at 6:23 p.m., revealed "...Pt (patient) just back from Dialysis...AV(arteriovenous) Graft Fistula...Thrill Palpable...Location of AV Graft Fistula L(left) wrist/forearm area...Pt is on dialysis 4X (times) per week..." Medical record review of the Patient Care Plan Report dated September 27, 2010, at 6:23 p.m. revealed there were no approaches or interventions to address the resident's need for dialysis or care of the Vascular access devices. Interview, with the DON, on October 5, 2010, at 11:15 a.m., in the Administrator's office, confirmed the resident's Care Plan did not address the resident's need for dialysis or care of the Vascular access devices and was incomplete.	F 281	committee. Recommendations from committee members will be used to facilitate policy and procedure changes related to the care planning process. Karla Woodby RN Karla Woodby, Director of Nursing 10/20/10 Danny Rymer, Pharmacy Director 10/20/10	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	F 514	Diana L. Miller, Administrator 10/20/10	

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F 514	Continued From page 4 services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the medical record was complete for one (#4) of ten residents reviewed. The findings included: Medical record review of resident #4's physician's orders dated September 20, 2010, revealed the resident was to receive the following medications: Citalopram (antidepressant) 20 mg (milligrams) by mouth daily; Furosemide (diuretic) 20 mg by mouth twice a day; and Klor-con (potassium) 10 meq (milliequivalent) by mouth twice a day. Medical record review of the September 2010, Medication Administration Record (MAR) revealed there was no documentation the resident received the following meds: Citalopram 20 mg on September 24, 2010; Furosemide 20 mg on September 26, 27, 29, and 30, 2010, at 5:00 p.m.; and Klor-con 10 meq on September 27 and 30, 2010, at 9:00 p.m. Interview on October 6, 2010, at 10:10 a.m., with the Director of Nursing, in the conference room, confirmed there was no documentation the resident had received the following medications: Citalopram 20 mg on September 24, 2010; Furosemide 20 mg on September 26, 27, 29, and 30, 2010, at 5:00 p.m., and Klor-con 10 meq on September 27 and 30, 2010, at 9:00 p.m.	F 514	Resident #4 – Nurse failed to properly document medication administration. Immediately, an Unusual Occurrence Report was completed and medical staff was notified of the missing documentation. Initially, nursing staff participated in a review of medication administration documentation. Any further errors on the MAR will result in individual counseling/education for the nurse. Random audits of medication administration documentation will be conducted. Documentation errors will continue to be reported on the Unusual Occurrence report and will be reviewed on a weekly basis for two months and then a monthly basis for 10 months. These findings will be reported and discussed at the Performance Improvement (PIC) Committee. Additional actions will be taken as deemed appropriate by the committee members. Karla Woodby RN Karla Woodby, Director of Nursing 10/20/10 Diana L. Miller Diana L. Miller, Administrator 10/20/10	11/5/10

OCT 25 2010

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN3316	A. BUILDING _____ B. WING _____	10/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SISKIN HOSPITAL SUBACUTE REHAB	ONE SISKIN PLAZA CHATTANOOGA, TN 37403

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N 000	Initial Comments During the annual Licensure survey conducted on October 4-6, 2010, at Siskin Hospital Subacure Rehab, no deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		

Division of Health Care Facilities

Deanna Miller, NHA TITLE 10/20/10 (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

OCT 25 2010

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 11/20/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445420	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SISKIN HOSPITAL SUBACUTE REHAB	ONE SISKIN PLAZA CHATTANOOGA, TN 37403

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K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure electrical wiring is installed in accordance with NFPA 70. The findings include: Observation on October 4, 2010 at 10:45 a.m. revealed numerous low voltage cables and wires installed above the ceiling are laying on the ceiling tiles in both east and west corridors. (NFPA 70).	K 147	On inspection of issue, it was determined that Southwest Communications failed to properly strap cables and wiring while installing a new patient call system. This vendor was contacted and will re-enter the facility during the week of 10/18/10 to correct this oversight. The problem will be resolved by re-strapping the cables and wires to appropriate hangers. To avoid further problems, the facilities director will check cable strapping following any future work by outside contractors. Jim Allyn 10/20/10 Jim Allyn, 10/20/10 Facilities Director Diana L Miller Diana L. Miller, 10/20/10 Administrator	10/22/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Diana L Miller, NHA 10/20/10

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